MassHealth
*The Commonwealth of Massachusetts*
*Executive Office of Health and Human Services*
*Office of Medicaid*
*www.mass.gov/masshealth*

**Name:** _____

**SSN:** _____

**Date:** _____

# NURSING FACILITY ELIGIBILITY

This notice is sent in response to your request for approval of MassHealth payment of nursing-facility services. You will receive a separate notice about your financial eligibility.

## 1. Administrative Approval

Mass Health has determined:

☐ you are eligible for MassHealth payment for 30 days. Your continued eligibility is subject to review.

## 2. APPEAL RIGHTS

**You have a right to appeal this decision.** (Please see attached information about your right to appeal through the Fair Hearing process.)

**OFFICIAL USE ONLY**

**Code:** _____ _____
Executive Office of Elder Affairs

**Date:** _____